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ABSTRACT

Alcoholism, and particularly alcoholism in the family, is an unsolved medical and social problem. Addictive drinking results in several social and psychological problems, most of which are caused by a change in brain function. Excessive drinking of alcoholic beverages operates as a stressor and produces alkaloids at the base of the brain that are closely related, chemically, to morphine. Not only a sedative, alcohol also has a stimulating effect on the brain. The difference in the duration of sedative and stimulating effects promotes continual drinking by alcoholics, who are not prepared to allow the stimulation to decline on its own. Such excessive drinking is one element of the diagnosis of alcoholism; other elements are problems arising from that drinking and compulsion to continue. The sequence of events in withdrawal is fairly regular, and the alcohol withdrawal episode is largely over after approximately 3 days. Psychological defenses of alcoholics and their families such as denial are numerous and must be relinquished for intervention to be effective. Phases in the development of alcoholism are evident, as are patterns in the behavior of the alcoholic's spouse and children. Alcoholism is not symptomatic of an underlying psychiatric disorder but causes problems in the patient's total environment, including his or her personal health. The problem of alcoholism demands that legal and medical professionals modify their attitudes. Recently, significant progress in understanding the disease has been made in public hospitals and universities. (RH)

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Selected Papers

Unit for Child Studies

Number 34

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ALCOHOLISM AND THE FAMILY

by

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ALCOHOLISM AND THE FAMILY

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I would like to stress that I am not a psychiatrist or paediatrician, but a consultant physician who has been interested in this subject of alcoholism for some thirty years. Alcoholism, and particularly alcoholism in the family, is one of the greatest unsolved world-wide medical and social problems. The problem of a child in an alcoholic family is largely unstudied and unresearched in Australia.

The magnitude of the problem of alcoholism can be gauged from the fact that studies at the Royal Prince Alfred Hospital in Sydney in 1978 (Williams et al.) revealed that approximately 20% of patients were in general medical wards directly due to alcohol caused disease. If one included alcohol-related problems in all patients the figure rises to 30%. It has been estimated by the Australian Foundation on Alcoholism and Drug Dependence (FRATADD) that about 50% of prisoners in goal, half the serious crime, and half the divorces, are due to alcohol-related diseases.

Genetic studies (Goodwin, 1976) have shown that a male child has a fourfold chance of developing alcoholism if the father is an alcoholic. However, there is very little literature on female adult alcoholics in this country, nor on the adult children of alcoholics. It has been noted, however, that the child of an alcoholic family may either do well or do badly at school. This will be discussed later.

I should like to emphasise again that my approach is that of a consultant physician, not a psychiatrist. From this standpoint I will use the definition of an alcoholic that states "The alcoholic is one whose drinking causes a continuing and growing problem in any department of his/her life." (Marty Mann, 1952). It matters little in what form the alcohol is taken; the chemistry remains the same - C_2H_5OH. Alcohol is always a sedative drug, no matter what its colour, taste, odour or dilution. In other words, we are dealing, when we talk of alcoholism, with a chronic state of intoxication due to a commonly used sedative drug. Stanley Gitlow (1980) of New York, has called alcoholism a form of sedativism akin to chronic poisoning with barbiturates, benzodiazepines, heroin, etc.

Under these conditions, there will always be resulting problems. The alcoholic will have increasing difficulties of growing proportions in health, domestic situations, job, legal situations, sexual control, social adjustment (gambling, loss of friends), and so on. In fact, we can group these problems in a circle around the centrally addicted drinker. The alcoholic always sees the problems which surround him/her as *causing* his/her addictive drinking whereas, in reality, the *alcohol* is the cause of the problems. Drinking can be seen as causing problems such as health and legal problems. For instance, there is never any suggestion that cirrhosis of the

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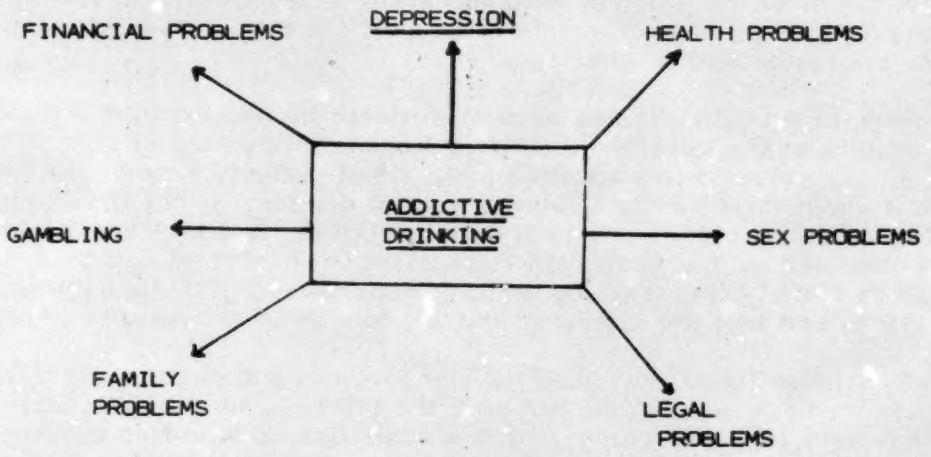
liver causes the alcoholism; clearly, it is the alcohol abuse which has led, over a number of years, to cirrhosis of the liver. A similar situation exists with most of the problems surrounding the alcoholic. In cirrhosis, incidentally, there is a chronic progressive proliferation of connective tissue within the liver, the degeneration of connective tissue within the liver, the degeneration of liver cells, and either enlargement or reduction in size, of the liver generally. Similarly, changes may be caused to the actual structure of the brain after alcohol has been perfusing it for a number of years. However, most of the manifestations in the alcoholic are caused by a *change in brain function*, and no improvement can be expected until the perfusion by alcohol has stopped.



Three features which enable us to diagnose alcoholism are:

1. *Excessive drinking* - the patient has been drinking to excess, usually over twelve standard drinks per day, for a number of years.

2. *Problems arising* directly out of that drinking (as can be seen in the diagram above).

3. *Compulsion* to continue drinking or inability to stop drinking. This third factor is often overlooked by students of alcoholism. It constitutes total lack of ability to control the drinking once the drink is ingested, so that he/she will eventually end up behaving in a stereotyped habitual manner, and usually proceeds to drink to self oblivion.

There may be habitual heavy drinking with severe organic bodily changes (e.g. cirrhosis of the liver) so that when he/she stops drinking, there are severe withdrawal symptoms. The deterioration seen in the alcoholic is usually progressive, but it is not necessarily steady. There may be plateaux of deterioration, but usually, the condition gradually worsens, leading to domestic discord, deterioration in health, becoming unenployable at an earlier age, etc.

One aspect of the disease of alcoholism which is not accorded due recognition is the disturbances of brain function which alcohol, in excess, produces. In this, the body chemistry is involved in many ways. An example is

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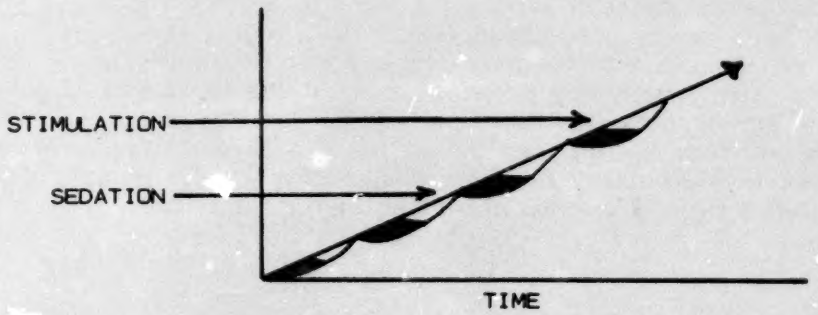
the production of substances of plant origin (alkaloids), at the base of the brain, which are closely related to morphine. The body has the capacity at certain sites at the base of the brain to produce these substances called endorphins or enkephalins, which then spread throughout the bloodstream to receptor sites in the higher layers of the brain. These receiving or receptor sites are obviously there to receive the morphine-like substances produced by the brain, and, in certain circumstances, under stress, they are increased many fold. One of the stresses which can produce excessive production of these substances from the brain, is alcohol. It has been found that in alcohol-dependent rats, the morphine-like substances may be produced in twentyfold the amount that is normally produced. These substances may be related to the phenomenon of craving which is seen in the alcoholic, though this idea requires a great deal more research.

Furthermore, the action of alcohol on the brain is not merely depression or sedation, but also stimulation. The problem is that the sedative affect lasts only 2-3 hours compared to 8 hours for the stimulant effect, and this means that after a bout of drinking, the alcoholic will be left with stimulation but no sedation and this, in turn, leads to agitation, anxiety and nervous tension. I refer to this condition as "organic anxiety". It may be relieved by the ingestion of another large amount of alcohol commonly known as "the hair of the dog that bit you".



Each time the period of sedation is over, pulse rate is seen to be more rapid, there is perspiration and increase in breathing and the pupils are dilated, all due to stimulation of the nervous system by alcohol. Now, an average social drinker learns that this stimulation will subside by the following day, and is prepared to let it do so. The alcoholic does not recognize this, and is not prepared to allow the stimulation to decline. The extraordinary mystery is that the alcoholic, having just managed to recover from one bout of withdrawal, has a monumental inability to learn from this experience. He/she has no sooner recovered from one bout than he/she is planning to start all over again.

The actual sequence of events in withdrawal is fairly regular and, in a person who has been drinking very heavily, the symptoms are:

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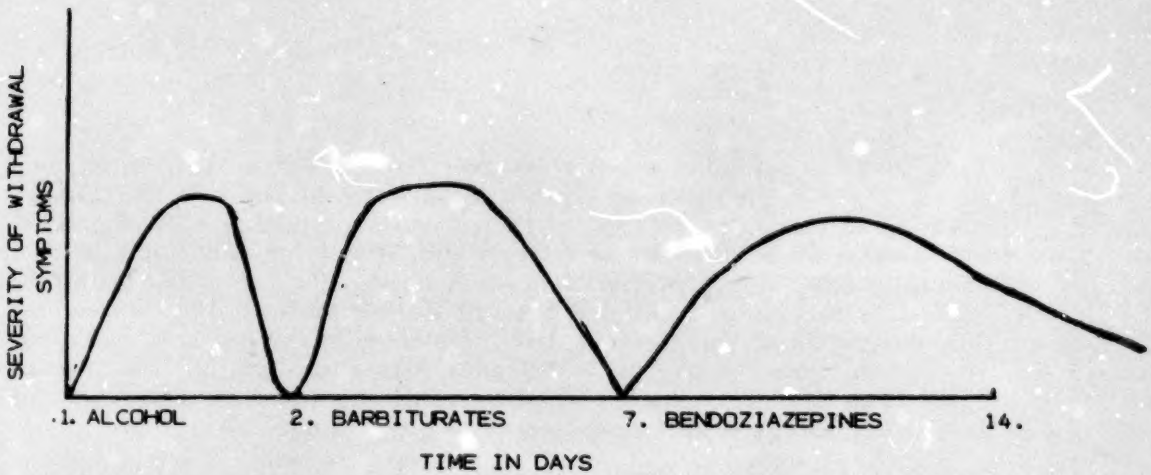
1. tremors or shaking of any part of the body - these may be a fine tremor or strong enough to visibly shake the whole body. Usually this occurs about 12 hours after the last drink;

2. hallucinations about 24 hours after the last drink, which consists of hearing and seeing things that are not there. Having more alcohol may alleviate this state;

3. a fit occurring about 36 hours after the last drink when the blood alcohol level falls further;

4. delirium tremens, a more prolonged state, lasting days, or possibly a week or two, when the alcoholic wants to be on the go all the time. This may require restraint, and like the manifestations of withdrawal occurs because of the removal of the sedative affects of alcohol when he/she stops drinking, hence they are withdrawal symptoms.

After approximately three days in hospital, the alcohol withdrawl episode is largely over, but there may be a second hump of withdrawal and, if so, it is likely to be due to the fact that the patient has been ingesting barbiturates as well. Barbiturates are sedative-hypnotic preparations which cause sedation and may induce sleep and produce exactly the same sequence of events (when the drug is withdrawn) as does alcohol. The barbiturate withdrawal period should usually be finished by the end of the first week. However, there may be yet a third hump of withdrawal if the patient has been taking benzodiazepines. This begins about the seventh day and may be quite prolonged, perhaps as long as 2-3 weeks. During this period, the patient may present paranoid delusions and rapidly changing states of anxiety and depression which can last for some weeks. It can be easily seen from the diagram below that if a patient stops taking his/her drugs a week or so before he/she stops drinking, he/she may suffer from muitiple drug withdrawals occurring at the same time.



The next diagram depicts two faults. The alcoholic may be locked into the areas on the left hand side by his personality and his body chemistry,

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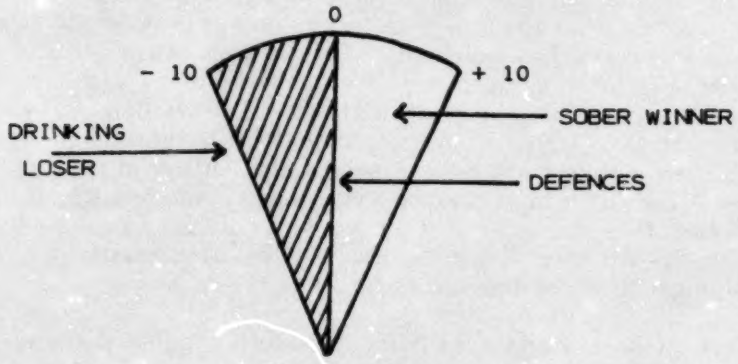
as well as by social factors. We may refer to the "drinking loser" on the left-hand side and to a "non-drinking winner" on the right-hand side. The alcoholic totally refuses to face the fact that he is trapped into the grey side of his existence by certain psychological mechanisms or defences.

The major defence is denial. Most characteristic of the alcoholic and his/her family is the denial of the alcoholism. Often, the family will go out of their way to make excuses for the drinking. To make a diagnosis less than "alcoholism" is to cover up the problem thus preventing the alcoholic suffering from any of the consequences of his/her drinking. In treating the alcoholic, it is essential that denial and other defences such as rationalisation, projection, minimising, reservations and intellectualising, should all be broken down. The family, by withdrawing its psychological props, can make the alcoholic take responsibility for the consequences of his/her drinking, and turn him/her away from a "drinking loser" into a "sober winner".



The alcoholic may be induced to join Alcoholics Anonymous, the programme which offers most for the majority of people. AA has all the features of behavioural therapy, though this has not been recognised by professionals to a great degree - thus, their power of example, rewards and association are clearly demonstrated in the therapy of Alcoholics Anonymous. AA insists that the patient stop drinking completely. This abandonment of drinking means that the sedativism ceases and the subject can them use the AA programme to mature emotionally. Until the alcoholic abandons drinking he/she will persist in his/her chronic delusional state and can be seen to be suffering from chronic alcohol poisoning. This is so because alcohol perfuses all body tissues and a high concentration damages the brain, liver and the heart, and produces a great disruption in brain function. In addition, alcohol diffuses throughout the cerebrospinal fluid into the lymph of the body which bathes the cells of every organ.

The Foundation for Research and Treatment of Alcoholism and Drug Dependence in New South Wales, has, since 1975, introduced into companies what is known as Alcoholism in Industry Programmes, and has led the field in occupational alcoholism in NSW. Intervention, by a supervisor in industry, on the basis of poor job performance, can prevent a deteriorating alcoholic on the job, losing his/her job, or perhaps his/her life. Families, too, present a superb opportunity to intervene, but often the non-alcoholic wife/husband continues to deny that the patient is "a real alcoholic". She/he

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thus enables the alcoholism to continue, and enabling of this type must go before there is any possibility of help through intervention.

Alcoholism develops in four phases:

1. The pre-alcoholic phase - in which the drinking may not be noticeably different from that of the average social drinker except, perhaps, that the drinker tends to drink more rapidly and with a greater sense of urgency.

2. The prodromal phase - in which the subject often has an imperative need to drink at a certain time of day. He/she is preoccupied with the preservation of lines of supply, and a week-end without alcohol is unthinkable. If drink is not available, panic can occur. Often, he/she can do little, even at this fairly early stage, without the aid of alcohol.

3. The crucial phase - here there is a loss of control of the drinking pattern so that on most occasions the alcoholic drinks to drunkenness and oblivion. This is perlexing for the alcoholic, and it is in this phase he/she is likely to be admitted to hospital for treatment of the complications of alcoholism. It is likely, too, that at this stage, his/her job will be threatened. It is only at this time that most people seek help, either directly or through an Alcoholism in Industry Programme, or through the family. Hopefully, sooner or later, he/she comes to realise that this represents his/her "rock-bottom". This degree of insight might be enough to make the alcoholic seek treatment.

4. The chronic stage - with irreversible organic disease, particularly in the brain, liver and heart.

The alcoholic's spouse often acts as an enabler. He/she tends to protect the alcoholic from the boss by making excuses and covering up for him/her but. eventually, there is likely to be some crisis, followed by promises from the alcoholic and disillusionment and disappointment for the spouse. In her agitation and anxiety, a wife is likely to be prescribed drugs and may become drug dependent. Her central feeling is one of guilt and rejection. She can be helped if she can be encouraged to talk things out for the sake of her own feelings.

According to Sharon Wegscheider (1981) the children in an alcoholic family follow certain patterns too. Thus:

the first child - often feels that he/she must perform exceptionally well in an effort to heal the whole family's illness. Therefore, he/she may do particularly well at school or in sport and feels that he/she is responsible for curing the family's ills.

the second child - may be the family scapegoat who bears the blame for the family's plight. He/she tends to act out his/her feelings and behaves as if he/she does not care, though he/she may be deeply hurt inside. The child, if a daughter, is in danger of pregnancy, drug addiction and adolescent suicide.

the fourth child - is the family jester or mascot, and has a central core of insecurity and fear. They may become hyperactive and are often treated as hyperactive children. He/she is regarded as

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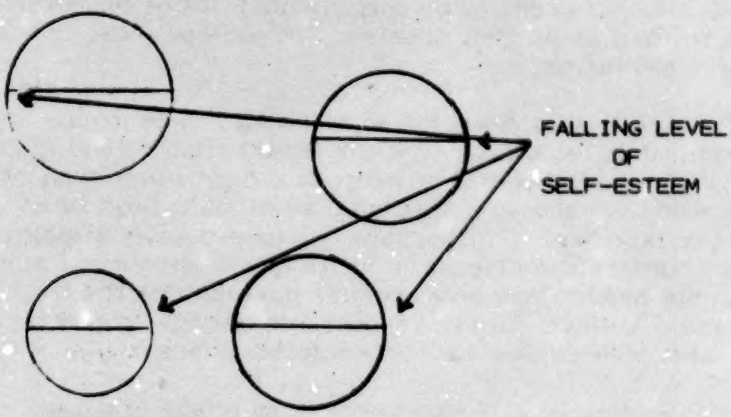
a little bit of fun for the family.

These patterns are greatly exacerbated in an alcoholic family, though they exist in families disturbed for other reasons as well. The important point to elicit in treating the alcoholic family, is that someone is enabling the drinking to occur, by giving his/her tacit approval and consent to the alcoholic. This person is often acting out of love, care and concern, but is taking responsibility for the whole family. A great deal can be achieved by asking such a person: "Are you willing to share your feelings?" The family can be best treated by joining Alcoholics Anonymous, Alanon and Alateen. The family is advised to visit a physician who understands alcoholism in the family and to see an alcoholism counsellor and a family counsellor well versed in handling the alcoholic family. Relaxation therapy and assertiveness training may be helpful adjuncts.

Wegscheider (1981) also sees the dysfunctional alcoholic family as being like a mobile. If you agitate one section, the activity spreads to all other segments. This is characteristic of the dysfunctional family, but is clearly apparent in the alcoholic family.

Wilkinson et al (1969) has noted in a clinic series that if the husband is an alcoholic, the wife has a 12% chance of being an alcoholic, too. On the other hand, if the wife is the alcoholic, the husband has a 50% chance of being, or becoming an alcoholic.

The point which should be emphasised, is that the alcoholic is an addicted individual. Until the addiction is treated in its own right, and not merely as a symptom of an underlying personality disorder, little progress will be made. Alcoholics suffer from clinical depression, and the insecurity and inconsistency within the family affects the children. Thus, depression of mood in the whole family tends to occur, coupled with its blood brother, anxiety. Both are devastating. Addiction to alcohol is similar to addiction to heroin, and the addicted family member is perplexed at his/her inability to stop drinking, and suffers from lowering of self-esteem on that account. The alcoholic fully intends to keep his/her promises made to the wife/husband or whole family, but does not realise that alcoholism is an organic disease with strong moral and other components. At each drinking episode there is a diminution in the level of self-esteem which embraces the entire family. Anxiety and depression increase as the self-esteem falls, forming a vicious downward spiral. The alcoholic usually has the illusion that "this time I'll be able to control it."



DRINKING CYCLES

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A responsible family member, physician, surgeon or employer has to take some sort of action before the alcoholic succumbs to liver failure, pancreatitis, or psychiatric disorder. In medical terms, the alcoholic is in grave danger of being treated symptomatically rather than having the basic problem which is the alcohol addiction, treated. With intervention, recovery frequently occurs.

Intervention may occur on the job through an efficient supervisor who watches and monitors job performance closely, through the family where the child can be presenting symptoms with psychosomatic disease, or the wife may seek help for her own nervous tension, depression or chronic anxiety. It may also occur through the physician, particularly in those cases in which it is difficult to make any organic diagnosis by the usual methods of history taking, examination and special investigation. Under these circumstances, one must always consider the possibility of alcoholism. It must be stressed again, that this alcoholism is not symptomatic of an underlying psychiatric disorder, but causes the problems in the patient's total environment, including his/her personal health. Therefore, it needs to be treated for what it is, an addiction in its own right.

The child of an alcoholic parent may develop psychosomatic disorders such as persistent abdominal pain and this, and many skin diseases, too, tend to clear up in family members, once the alcoholism has been eradicated. One alcoholic stated that her child had been a sufferer from abdominal pain for several years during the time she had been drinking. The abdominal pains cleared up entirely, and almost immediately, when she became sober with the help of Alcoholics Anonymous. Furthermore, her husband had suffered from a diffuse skin rash which likewise cleared when their family tension settled down. Neither have recurred.

The effects of alcohol during pregnancy in the alcoholic patient can lead to both stunted physical and emotional growth retardation and minor congenital defects in the unborn child. A woman may not be aware that she is pregnant and may continue drinking during the first three months, which is the most dangerous time of a pregnancy. Some of the foetal changes can be quite major, even with modest drinking. It is probably unwise for a female of child-bearing age to drink at all.

In psychiatric illness, the incidence of alcoholism is high. One study (Smithurst, 1965) in Brisbane showed that 48% of males in psychiatric hospitals had an alcoholic problem, whilst 30% of women in psychiatric treatment had an alcohol problem. In each of these cases the real diagnosis was alcoholism.

How effective is treatment for an alcoholic? The modus operandi for such a person is *total abstinence*. Quite apart from relieving the addiction, total abstinence is necessary because a high proportion of alcoholics have evidence of liver damage, 70% have significant high blood pressure, and some have jaundice. This organic picture usually subsides with total abstinence, unless the disease is in its late and terminal stage when chronic irreparable damage to many organs, particularly the liver and the brain, may occur. Unfortunately, irreparable damage to the family may also occur, and divorce may be contemplated or actual.

The legal implications of alcoholism in marriage are immense. The present situation is that divorce may be granted where a marriage has "irretrievably broken down". When alcoholism is involved, it is difficult to say that the marriage has been irreparably damaged unless the treatment has been given a persistent and determined trial. Not only does the alcoholism

have to be treated directly, but the family needs Alanon and Alateen. Otherwise, only part of the disease is being treated. It must be remembered that alcoholism has a great effect on family dynamics since alcohol addiction may be as strong as heroin addiction.

One may question whether it is possible for the alcoholic to stop drinking in the early stages of this disease. It appears, that in the early stages of the disease, an alcoholic may stop drinking for many years. A change of job, wife/husband, or diminishing stress, may delay the onset of the disease and, perhaps, prevent it. It has been shown that controlled drinking programmes (e.g. the "Rand Reports", 1978, 1981; Sobell, 1978) are largely ineffectual. This is my opinion, and it is supported by many researchers throughout the world (Pendery, 1982; Einstein, 1983; Carroll, 1981). It must, however, be admitted that others believe that some form of controlled drinking, in some cases, is practicable. As I said earlier, in the pre-alcoholic or, perhaps, even during the prodromal stage, a change in the drinking patterns may be possible. However, when the crucial stage supervenes, the diagnosis is firmly established. "Controlled drinking" is, in my opinion, likely to be futile.

There is some apathy in medical circles regarding the understanding of alcoholism and alcoholism in the family, but much headway has been made in the last few years, both in public hospitals and universities. The Royal Australasian College of Physicians, in 1982, made a public physicians' statement which is quite extensive. The Australian Medical Society on Alcohol and Drug Related Problems has recently been formed. It has a very active programme and membership, and publishes its own journal, *The Australian Alcohol/Drug Review.*

There is still some resistance and occasional hostility from some members of the legal and medical professions, but the immensity of the problem makes a modified attitude imperative. The Australian Foundation for Research and Treatment of Alcoholism and Drug Dependence in Canberra states that, Australia-wide, about 50% of road accidents are alcohol related and between 20 - 30% of divorces. Further information can be obtained from this organisation at Box 477 Canberra City, ACT 2601. Intervention in both the medical and legal spheres is necessary and urgently required if we are to overcome the growing problems of alcoholism and its related difficulties, both individual and communal.

Paper based on seminar presented at the Unit for Child Studies, University of New South Wales, May, 1984.

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